

REPORT OF RABIES POST-EXPOSURE TREATMENT - Page 1 of 2

Indiana State Department of Health
State Form 51726 (10-04).

To be completed by the treating physician or hospital representative at the completion of treatment; forward to the local health officer where the patient resides.

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this: ☒ Not like this: ☒ Mark mistakes like this: ☒
- 4 Print capital letters only and numbers completely inside boxes.

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- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY

Section 1. Demographic Information

Last Name

First Name

MI

Phone Number

Number & Street Address

City

State

ZIP Code

County

Date of Birth

Age

Race:

☐ Asian ☐ White ☐ Black or African American ☐ Other/Multiracial ☐ American Indian or Alaska Native ☐ Unknown ☐ Native Hawaiian or Other Pacific Islander

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Sex:

☐ Male ☐ Female ☐ Unknown

Is Age in day/mo/yr?

☐ Days ☐ Months ☐ Years

Section 2. Clinical Information

Physician/Hospital Where Treatment Initiated

Physician/Hospital Address

City

State

ZIP Code

Physician/Hospital Phone

Type of Human Exposure (check all that apply):

- ☐ Multiple Bite
- ☐ Single Bite
- ☐ Scratch
- ☐ Contamination of an abrasion, cut, open wound, or mucous membrane with **SALIVA** or **CNS** fluid
- ☐ Unknown
- ☐ Other, specify: _____

Part of Body Exposed (check all that apply):

- ☐ Face/Neck/Head
- ☐ Finger
- ☐ Hand/Foot
- ☐ Leg/Arm
- ☐ Trunk
- ☐ Other, specify: _____

Type of Rabid/Suspect Rabid Animal Involved in Exposure:

- ☐ Bat ☐ Dog ☐ Skunk ☐ Ferret
- ☐ Cat ☐ Raccoon ☐ Fox ☐ Unknown
- ☐ Other, specify: _____

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Section 2. Clinical Information (Continued)

Circumstances of Exposure (check all that apply):

- ☐ Completely unprovoked attack by rabid/suspect rabid animal
- ☐ Attacked while entering area guarded by rabid/suspect rabid animal
- ☐ Provoked attack (feeding/petting/touching/playing/picking up/treating/nursing/examining/consoling rabid or suspect rabid animal)
- ☐ Treating/nursing/examining/consoling pet/animal which had conflict with suspect rabid animal
- ☐ Skinning/dressing rabid/suspect animal carcass
- ☐ Unknown
- ☐ Other, specify: _____

____/____/____ ____/____/____
Date of Exposure Date Treatment Began

Rabies Status of Exposing Animal:

- ☐ Tested positive
- ☐ Tested negative
- ☐ Under confinement
- ☐ Not available
- ☐ Testing requested but owner did not permit
- ☐ Other, specify: _____

Type of Treatment:

- ☐ HRIG plus 5 doses of vaccine
- ☐ 2 doses of vaccine (for pre-vaccinated individuals)
- ☐ Incomplete course (treatment stopped after animal determined to be negative for rabies)
- ☐ Incomplete course (treatment stopped by patient)
- ☐ Treatment course initiated by patient lost to follow up
- ☐ Unknown
- ☐ Other, specify: _____

Comments:

Name of Person Submitting Report

Title

Signature

____-____-____
Phone Number

Name of Reporting Health Officer/Representative

____/____/____
Date Initially Reported

Name of Health Department